

DCFS SEXUAL HARASSMENT COMPLAINT FORM

Complainant:			
Work Address:			
Phone:		Bureau/Section/Division and Location:	
Complainant's Job Title:			
Name of Person Against Whom Complaint Is Filed (Respondent):			
Work Address:			
Relief Sought:			
Date Complaint Occurred: <small>(must be within past 300 calendar days)</small> <i>Note: See DCFS Civil Rights Policy 2-03 for information regarding discrimination based upon race, color, age, covered veteran, sex, religion, disability, national origin, genetic information, or political affiliation (DCFS and state processing only)</i>			
Detailed Description of Complaint <small>(may add additional page if necessary)</small>			
Witness(es) or Contact Person(s)			
Signature of Complainant:			
			Date: